Statewide Health Care Core Measure Set
Technical Work Group on Acute Care Measures
Meeting #8: Tuesday December 2, 2014
9:00 – 11:00 am
Meeting Summary

Agenda Item	Summary of Workgroup Activity and/or Action(s)
I. Welcome and Introductions	Susie Dade, Deputy Director of the Washington Health Alliance welcomed the group to the last meeting of the Technical Work Group on Acute Care Measures. Workgroup members introduced themselves. Meeting attendance is recorded on page two of this meeting summary. The slide deck for this meeting is available upon request; please contact Susie Dade at sdade@wahealthalliance.org
II. Review of Public Comment on Proposed Measures	Ms. Dade provided an overview of the feedback received through the public comment process. Sixty-seven individuals responded to the on-line survey, with 47 complete responses (all questions answered). Responses to the survey were as follows: *"I clearly understand the purpose of the statewide core measure set."* 70% Yes; 24% Somewhat; 6% No (N = 67) *"Have you had the opportunity to review the final draft list of proposed measures?"* 82% Yes; 14% Somewhat; 4% No (N = 66) *"Recognizing that this is considered a 'starter set' that will evolve over time, do you agree with the recommended measures?"* 32% Yes; 61% Somewhat; 7% No (N = 56) *"Do you feel there are measures/topics that should not be included on the core measure set, but currently are?* 60% Yes; 40% No (N = 53) *"Do you feel there are any measures/topics that should be included on the core measure set, but currently are not?"* 57% Yes; 43% No (N = 49) *"Do you feel the process to select the draft core measure set was communicated in a clear and timely manner?"* 57% Yes; 37% Somewhat; 6% No (N = 51) There were a number of narrative comments, all of which were shared with the workgroup verbatim. The overall themes included in the narrative comments can be summarized into the following topics: • Burden of measures set on providers • ED measures • Oral health • Integration of behavioral/physical health • Size of measure set (too big) • Lack of measures that impact cost • Importance of stratification/focusing on social determinants of health • Low volume/small providers/rural health

	• Advanced care planning/end of life • Medications Workgroup members reflected that the input received via the public comment period was positive overall with some suggestions for specific measures that might be modified, eliminated and/or added.
III. Discuss and Finalize Recommended Measures	The workgroup discussed each of the specific acute care measures that were impacted by one or more comments/suggestions made during the public comment period. Workgroup members were instructed that, for each measure, they had the choice to: (1) maintain their recommendation(s) as is/make no change; (2) eliminate a measure; or (3) add a new measure. Starting on page 3 there is a summary of the discussion and action taken regarding each measure under consideration. The workgroup noted that they appreciated the public's input.
IV. Next steps and wrap-up	This was the last meeting of the Acute Care Measures Workgroup. Ms. Dade thanked committee members for the time and energy that they devoted to this important (and rapid!) process. The Performance Measurement Coordinating Committee is meeting on December 17 from 1:00 PM-5:00 PM to finalize the measure set.

December 2, 2014 Attendance/Committee members:

Attendance/Workgroup members:

Committee Member	Organization	ATTENDED in person	ATTENDED by Webinar/Phone	DID NOT ATTEND
Connie Davis	Skagit Regional Health			X
Mark Delbeccaro	Seattle Childrens		X	
Tim Delit	University of Washington		X	
Sue Dietz	Critical Access Hospital Network		X	
Jennifer Graves	Washington State Nurses Association	X		
Patrick Jones	Eastern WA University Institute for Public Policy & Economic Analysis			X
Kim Kelley	WA State Department of Health	X		
Dan Kent	Premera Blue Cross		X	
Michael Myint	Swedish Health Services			X
Terry Rogers	Foundation for Healthcare Quality	X		
Carol Wagner	Washington State Hospital Association			X

Attendance/Staff:

Name	Organization
Susie Dade	Washington Health Alliance
Teresa Litton	Washington Health Alliance
Lena Nachand	WA State Health Care Authority
Beth Waldman	Bailit Health Purchasing

Attendance/Other (Public):

Kate Cross, Washington State Department of Health
Cheryl Farmer, Washington State Department of Health
Ann Simons, GlaxoSmithKline

Measure to Reconsider	Summary of Public Comment	**ACTION BY WORKGROUP**	Summary of Workgroup Discussion
Follow-up After Hospitalization for Mental Illness @ 7 days, 30 days (Measure #17)	Long been a controversial measure; no mechanism to capture engagement and outreach for non-enrolled consumer	**MAINTAIN RECOMMENDATION; KEEP MEASURE ON THE CORE MEASURE SET**	Workgroup recognizes that measure is not perfect, but it is an NCQA-HEDIS measure in wide use and is NQF-endorsed. Acknowledge the desire to improve the depth and accuracy of measurement in this important area, but also recognize that systems do not exist today to support capture of follow-up data for uninsured or non-enrolled consumers by provider organizations or health plans.
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (Measure #29)	Evidence of coding behavior change to improve results on measure (coding for bronchitis dropped; coding for cough increased). Suggest using code cluster for URI.	**MAINTAIN RECOMMENDATION; KEEP MEASURE ON THE CORE MEASURE SET**	The workgroup discussed multiple topics: (1) shifting of coding away from "bronchitis" to improve performance has been reported; this type of shift is a risk for many measures and suggests a larger problem related to lack of a QI culture; (2) a URI code cluster is being used locally but is not vetted on a larger scale (not NQF or NCQA endorsed); (3) maintaining this measure on the list is important given known overuse of antibiotics and the significant public health issue that this raises.
Appropriate Testing for Children with Pharyngitis (Measure #22)	Measure penalizes clinicians who utilize a validated decision rule (based on clinical history and findings rather than a rapid strep test) and who treat a high probability case.	**MAINTAIN RECOMMENDATION; KEEP MEASURE ON THE CORE MEASURE SET**	Committee clinicians don't see much use of such clinical rules, so this omission is not expected to affect the usefulness of the measure as an indicator of overuse of antibiotics.

Measure to Reconsider	Summary of Public Comment	**ACTION BY WORKGROUP**	Summary of Workgroup Discussion
Potentially Avoidable ED Visits (Measure #43)	Suggests replacing this measure with the following: # of ED patients returning to the ED with same or similar diagnosis within 72 hours of their initial visit X 100 This is a measure that hospitals can do something about and encourages community provider collaboration. Potentially avoidable services are too vague to measure and don't allow for the reason that a large number of patients are sent to the ED (sent by their physician).	**MAINTAIN RECOMMENDATION; KEEP MEASURE ON THE CORE MEASURE SET**	Suggestion made by Rural Health Quality Network, indicating this is a measure they have been focused on. Workgroup noted that suggested measure reflects a combination of illness and access. It is not a substitute for the Avoidable ED Visit measure as it really measures something different. Workgroup noted that the suggested measure is similar to (but not the same as) Measure # 44 already on the list: Patients w/ 5 or More ED Visits without Care Guideline. Data source for the suggested measure over the longer term was reported to be unreliable as the RHQN is voluntary and in transition. Workgroup suggests considering suggested measure in the future. The potentially avoidable ED visit measure has limitations in that it is not certain that the visits are avoidable; also true that many patients told to go to ED by their physician. Nonetheless, this measure provides a meaningful indicator of potentially unneeded and costly use of ED services.

Measure to Reconsider	Summary of Public Comment	**ACTION BY WORKGROUP**	Summary of Workgroup Discussion
Stroke: Thrombolytic Therapy (Measure #48)	Measure should include adverse outcomes from thrombolytic therapy (morbidity/death); also needs to include contraindications. Science related to this therapy is still too controversial.	**MAINTAIN RECOMMENDATION; KEEP MEASURE ON THE CORE MEASURE SET**	Workgroup notes that the contraindications are already taken into account in the measure denominator; this is a Joint Commission measure and science is well established. Detailed clinical data related to adverse outcomes not readily available to support statewide reporting.
Complications/Patient Safety Composite (Measure #50)	NQF is currently reviewing and discussing potential changes to this AHRQ-sponsored measure. WSHA recommends postponing the measure until changes finalized. WSHA notes many of the 11 measures within this composite are on the list as individual measures.	**MAINTAIN RECOMMENDATION; KEEP MEASURE ON THE CORE MEASURE SET**	NQF regularly reviews proposals to modify measures; this is not the only measure in the measure set for which changes are being considered. While it is important to have an active process for monitoring changes to measures by NQF, NCQA and other national bodies, the work group did not think that measures should be removed just because the certifying body is considering changes. Also, measures of the individual components are not included elsewhere in the recommended measure set and this is the only measure related specifically to patient safety and adverse events related to inpatient care." The composite was selected, in part, because rates on individual components can be very low, resulting in harder to understand results and unreportable data for many organizations (small N).

Other Topics Considered:

1. Measure stratification by race/ethnicity. Workgroup agreed that stratification of measure results is important and that we should do so as the data permits. Three of the acute care measures currently are recommended for stratification (Medicaid only). Group acknowledged that, currently, only Medicaid data permits this type of stratification using readily available data. County level reporting recommended for five measures which will add further information regarding rural/urban differences.
2. Psychiatric boarding times in ERs. Very important issue. It was noted that most (all?) hospitals are actively working on this issue and there is a statewide effort to address the shortage of appropriate beds. Workgroup thought that the topic did not have accurate, vetted measurement sources available for public reporting at this time.